

**EMS PROVIDER
REPORT OF EXPENDITURES FY 03
(make a copy of this form for each provider)**

COUNTY of LICENSURE: _____

Counties of Operation: _____

Name of EMS Provider: _____

Name of EMS Administrator (Print): _____

Re: Utilization of Funds Received from the EMS Trauma Care System Account

Total Amount of Allocation this Provider Received: \$ _____

Purchases/expenditures during period **September 1, 2002 - August 1, 2003:**

Copies of RECEIPTS ARE REQUIRED

Supplies:	Item: _____	Cost: \$ _____
	Item: _____	Cost: \$ _____
	Item: _____	Cost: \$ _____
	Item: _____	Cost: \$ _____

Education & Training: Course: _____
Persons Trained: _____ Date: _____
Cost: \$ _____

Equipment:	Type: _____	Cost: \$ _____
	Type: _____	Cost: \$ _____
	Type: _____	Cost: \$ _____

Vehicles:	Type: _____	Cost: \$ _____
	Type: _____	Cost: \$ _____

Communications Equipment:	Type: _____	Cost: \$ _____
	Type: _____	Cost: \$ _____

Other Operational Expenditures: _____

Anticipated Expenditures through **August 31, 2003**, if any: _____

Total Costs: \$_____

*Please prioritize and list anticipated needs for FY 2004 (9/1/03- 8/31/04): _____

*Please prioritize and list anticipated long-term system development needs: _____

Name of person completing report (Print):_____

Title:_____ Phone: _____

RAC/County Authorized Signature: _____Title:_____

Name (Print): _____ Date:_____

*Please attach additional page if necessary.